BlueCare Direct (HMO)

Outline of Coverage

Underwritten by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven Connecticut 06473
(800) 441-6634

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company.

Summary

Covered Service	
Individual Deductible	$1,500
Family Deductible	$3,000
Member Coinsurance	Not applicable
Member Cost-Share Maximum	Not applicable
Lifetime Maximum	$5,000,000
Daily Hospital Room and Board	
All Inpatient Admissions	Covered in full after payment of deductible
Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care	Covered in full after payment of deductible
Inpatient Rehabilitation Treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility	Covered in full after payment of deductible
Skilled Nursing Facility up to 120 days per Calendar Year	Covered in full after payment of deductible
Specialty Hospital 60 days per Member per Calendar Year (*for other than Mental Health and Substance Abuse services only).*	Covered in full after payment of deductible
Miscellaneous Hospital Services	
Emergency Room Treatment *(copayment waived if admitted)*	$75 copayment
Urgent Care Services	$50 copayment
Surgical Services	
Outpatient surgery In a licensed ambulatory surgical center *(including colonoscopy)*	Covered in full after payment of deductible
Medical Office Visit *(PCP visits only)*	$20 copayment
Anesthesia Services	
Anesthesia, anesthesia supplies and services *(In-hospital service)*	No cost share
In-Hospital Medical Services	
In-patient hospital/in-patient facility visits during a covered Admission	No cost share
Services of a Physician or Surgeon *(other than a medical office visit)*	No cost share

Covered Service	
Out-of-Hospital Care	
Well Child Care 6 exams from birth to 1 year of age 6 exams 1 through 5 years of age 1 exam every 2 Calendar Years 6 through 10 years of age 1 exam every Calendar Year 11 through 21 years of age	Up to age 13: No cost share Age 13+: $20 copayment
Adult Physical Examinations 1 exam every 5 Calendar Years 22 through 29 years of age 1 exam every 3 Calendar Years 30 through 39 years of age 1 exam every 2 Calendar Years 40 through 49 years of age 1 exam per Calendar Year 50 years of age and older	$20 copayment
Routine gynecological visit 1 visit per Calendar Year including pap smear	$30 copayment
Mammography One baseline screening for female 35 through 39 years of age One screening mammogram every Calendar Year for female 40 and older **Note: or more frequently if recommended**	No cost share
Other Benefits	
Immunizations and Vaccinations includes those needed for travel	$20 copayment
Hearing Exams 1 hearing exam every 2 Calendar Years	$20 copayment
Outpatient Diagnostic Services Including; MRI, MRA, CAT, CTA, PET and SPECT scans	$200 copayment
Outpatient Rehabilitation Services Outpatient rehabilitative and restorative physical, occupational, speech therapy (30 visit max.) Outpatient chiropractic therapy (20 visit max.)	 $30 copayment $30 copayment
Other Therapy Services Outpatient cardiac rehabilitation therapy for up to 36 visits per cardiac episode	$30 copayment
Radiation therapy Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a Hospital or free-standing dialysis center	No cost share
Allergy Testing and Treatment Allergy visits/testing Immunotherapy or other therapy treatments to a maximum of 80 visits over a 3 Calendar Year period	 $30 copayment $25 copayment
Ambulance Services ***Maximum for land:*** Paid according to the Department of Public Health Ambulance Service Rate Schedule ***Maximum for air:*** Paid according to the Department of Public Health Air Ambulance Service Rate Schedule	No cost share
Outpatient Treatment for Mental Health Care and Substance Abuse Care	$30 copayment
Infertility Services Office Visit Infertility drugs (with infertility diagnosis). The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30 day supply or 100 unit dose, whichever is greater.	 $20 copayment No copayment

Covered Service	
Private Duty Nursing	Not covered
Diabetic equipment, drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier	Covered according to prescription drug plan
Human Organ and Tissue Transplant Services $1,000,000 Lifetime Maximum	No cost share
Home Health Care Nursing and therapeutic services limited to 200 visits Home health aide services limited to 80 visits that are applicable to the 200 visit limit	No cost share
Infusion Therapy Unlimited Lifetime Maximum	No cost share
Durable Medical Equipment **Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of $1,000 within a two year period.**	No cost share
Ostomy Related Services	No cost share
Hospice Care *(inpatient)* 60 days per Calendar Year	Covered in full after payment of deductible
Wig Up to $350 maximum per member per calendar year	No cost share
Specialized Formula	$20 copayment
Penalty for Failure to Prior Authorize Elective Hospital Admissions, Partial Hospitalizations or Day/Night Visit Programs or Authorize a Medical Emergency Admission within 2 business days Penalty for Failure to Prior Authorize Covered Services Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than $500.	Not applicable

Century Preferred Direct (PPO)

Outline of Coverage – Major Medical Expense

Underwritten by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven Connecticut 06473
(800) 441-6634

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Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy.

Health Savings Account (HSA)-compatible products are shaded. This product is intended to be federally tax qualified. Approval by the Insurance Department does not guarantee tax qualification. Please seek the counsel of a tax advisor. This policy has not been submitted for approval by the IRS.

A Brief Description of Benefits

Covered Service	In-Network Services (*Out-of-Network Services)						
Individual Deductible**	$250	$1,500	$5,000	$10,000	$1,250	$2,500	$4,000
Family Deductible**	$500	$3,000	$10,000	$20,000	$2,500	$5,000	$8,000
Member In-Network Coinsurance (**Member Out-of-Network Coinsurance)**	20% (40%)	N/A (20%)	N/A (20%)	N/A (20%)	N/A (20%)	N/A (20%)	N/A (20%)
Member Cost-Share Maximum Individual Family	$1,500 $3,000	$3,000 $6,000	$10,000 $20,000	$15,000 $30,000	$2,500 $5,000	$5,000 $10,000	$5,000 $10,000
Lifetime Maximum	$5,000,000						
Daily Hospital Room and Board							
All Inpatient Admissions	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Inpatient Rehabilitation Treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Skilled Nursing Facility up to 120 days per Calendar Year	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Specialty Hospital 60 days per Member per Calendar Year *for other than Mental Health and Substance Abuse services only.*	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Miscellaneous Hospital Services							
Emergency Room Treatment	Deductible and In-Network Coinsurance (Paid as In-Network Service)						
Urgent Care Services	Deductible and In-Network Coinsurance (Paid as In-Network Service)						

*Out-of-Network Services are noted in parentheses.

**HSA Individual Member: The Deductible must be satisfied before any Covered Services will be paid by the Plan. HSA Family: The Family Deductible must be satisfied by either one Member or all Members collectively before any Covered Services will be paid by the Plan.

<table>
<tr><th>Covered Service</th><th colspan="2">In-Network Services
(*Out-of-Network Services)</th></tr>
<tr><td colspan="3">Surgical Services</td></tr>
<tr><td>Outpatient surgery
In a licensed ambulatory surgical center
(including colonoscopy)</td><td colspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td>Medical Office Visit</td><td colspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td colspan="3">Anesthesia Services</td></tr>
<tr><td>Anesthesia, anesthesia supplies and services</td><td colspan="2">Included in Hospital Services
(Included in Hospital Services)</td></tr>
<tr><td colspan="3">In-Hospital Medical Services</td></tr>
<tr><td>Inpatient hospital/inpatient facility visits during a covered Admission</td><td colspan="2">Included in Medical Services
(Included in Medical Services)</td></tr>
<tr><td>Services of a Physician or Surgeon
other than a medical office visit</td><td colspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td colspan="3">Out-of-Hospital Care</td></tr>
<tr><td>Well Child Care
6 exams from birth to 1 year of age
6 exams 1 through 5 years of age
1 exam every 2 Calendar Years 6 through 10 years of age
1 exam every Calendar Year 11 through 21 years of age</td><td rowspan="4">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td><td rowspan="4">No charge In-Network
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td>Adult Physical Examinations
1 exam every 5 Calendar Years 22 through 29 years of age
1 exam every 3 Calendar Years 30 through 39 years of age
1 exam every 2 Calendar Years 40 through 49 years of age
1 exam per Calendar Year 50 years of age and older</td></tr>
<tr><td>Routine gynecological visit
1 visit per Calendar Year including pap smear</td></tr>
<tr><td>Mammography
One baseline screening for female 35 through 39 years of age
One screening mammogram every Calendar Year for female 40 and older
Note: or more frequently if recommended</td></tr>
<tr><td colspan="3">Other Benefits</td></tr>
<tr><td>Immunizations and Vaccinations
includes those needed for travel</td><td rowspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td><td rowspan="2">No charge In-Network
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td>Hearing Exams
1 hearing exam every 2 Calendar Years</td></tr>
<tr><td>Diagnostic Services</td><td colspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td>Infertility Services
Office Visit
Outpatient Hospital
Inpatient Hospital</td><td colspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td>Infertility drugs (with infertility diagnosis)
The maximum supply of a drug for which Benefits will be provided when dispensed under any one prescription is a 30 day supply or 100 unit dose, whichever is greater.</td><td colspan="2">Deductible and Out-of-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td>Outpatient Rehabilitation Services
Restorative physical, occupational, speech therapy
(maximum combined 30 visits per calendar year)</td><td colspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td>Chiropractic therapy (maximum 20 visits per calendar year)</td><td colspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
<tr><td>Other Therapy Services
Outpatient cardiac rehabilitation therapy for up to 36 visits per cardiac episode</td><td colspan="2">Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)</td></tr>
</table>

*Out-of-Network Services are noted in parentheses.

Covered Service	In-Network Services (*Out-of-Network Services)
Radiation therapy Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a Hospital or free-standing dialysis center	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Allergy Testing and Treatment Allergy visits/testing Immunotherapy or other therapy treatments to a maximum of 80 visits over a 3 Calendar Year period	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ambulance Services ***Maximum for land:*** Paid according to the Department of Public Health Ambulance Service Rate Schedule ***Maximum for air:*** Paid according to the Department of Public Health Air Ambulance Service Rate Schedule	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Outpatient Treatment for Mental Health Care and Substance Abuse Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Private Duty Nursing Limited to $15,000 Per Calendar Year	Not applicable (Deductible and Out-of-Network Coinsurance)
Diabetic equipment, drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier	Covered according to prescription drug plan
Human Organ and Tissue Transplant Services $1,000,000 Lifetime Maximum	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Home Health Care Nursing and therapeutic services limited to 200 visits Home health aide services limited to 80 visits that are applicable to the 200 visit limit	No cost share ($50 deductible and 20% coinsurance) *For HSA-qualified plan: Deductible and In-Network Coinsurance* *(Deductible and Out-of-Network Coinsurance)* (The deductible for Home Health Care benefits accrues towards the member's annual deductible)
Infusion Therapy Unlimited Lifetime Maximum	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Durable Medical Equipment **Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of $1,000 within a two year period.**	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ostomy Related Services	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Hospice Care *(inpatient)* 60 days per Calendar Year.	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Wig Up to $350 maximum per member per calendar year	No cost share
Specialized Formula	$20 copayment
Penalty for Failure to Prior Authorize Elective Hospital Admissions, Partial Hospitalizations or Day/Night Visit Programs or Authorize a Medical Emergency Admission within 2 business days Penalty for Failure to Prior Authorize Covered Services Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than $500	$500 Hospital and 25% Physician of Maximum Allowable Amount (MAA) ($500 Hospital and 25% Physician) (of Maximum Allowable Amount (MAA)) $500 Hospital and 25% Physician of Maximum Allowable Amount (MAA) ($500 Hospital and 25% Physician) (of Maximum Allowable Amount (MAA))

*Out-of-Network Services are noted in parentheses.

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.

Exclusions and Limitations

The following services are not Covered Services under this Benefit Program, except when approved by Anthem Blue Cross and Blue Shield (Anthem) as part of Case Management.

1. Benefits for services which are not:
   a. specifically described in the Subscriber Agreement
   b. rendered or ordered by a Physician
   c. within the scope of the Physician's, Provider's or Hospital's licensure; and
   d. Medically Necessary Care for the proper diagnosis and treatment of the Member.
2. Benefits may be reduced or denied if subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not apply toward the Cost Share Maximums shown in the Schedule of Benefits.
3. Benefits for services rendered before the Member's Effective Date under this Benefit Program.
4. Benefits for services rendered after the person's Benefit Program has been rescinded, suspended, cancelled, interrupted or terminated. Any person obtaining services after his or her Benefit Program is rescinded, suspended, cancelled, interrupted or terminated for any reason will be solely responsible for payment of such services.
5. Care for conditions which are required by State or Local law to be treated in a public facility.
6. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
7. Services covered in whole or in part by public or private grants.
8. Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
9. Studies related to pregnancy except for significant medical reasons.
10. Simplified or self-administered tests and multiphasic screening.
11. Cosmetic Surgery or services performed primarily to improve appearance and not designed to restore body function or to correct deformity resulting from the treatment of malignancy or physical trauma.
12. Dental diagnosis, care, treatment, x-rays, or Appliances, for any of the diseases or lesions of the oral cavity, its contents or contiguous structures, the extraction of teeth, the correction of malpositions of the teeth and jaw, or for pain, deformity, deficiency, injury or physical condition of teeth, unless otherwise provided for in this Subscriber Agreement.
13. Surgical and non-surgical examination, diagnosis, including invasive (internal) and non-invasive (external) procedures and tests, and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: contrast and non-contrast imaging, arthroscopic and open surgical procedures, physical therapy, and appliance therapy such as occlusal Appliances (splints) or adjustments. Anthem will not provide benefits unless otherwise provided for by an Amendatory Rider to this Subscriber Agreement.
14. Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care.
15. Services for Custodial Care, Chronic Care and/or Maintenance Care.
16. Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.
17. Charges for the Member's room and board when the Member has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.
18. Drugs or medications, legend and over-the-counter, prescribed for use as an Outpatient, except as otherwise stated herein. (Prescription drug coverage is separate.)
19. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
20. Evaluation, treatment, procedures and Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling.

22. Obstetrical care or pregnancy, delivery, prenatal and postpartum care, including Inpatient care for a female Member and newborn. (For Century Preferred Direct only)
23. Vaccines other than routine immunizations or those needed for travel.
24. Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
25. No benefits are available for any service, care, procedure or program for weight or appetite control, weight loss, weight management or for control of obesity even if the weight or obesity aggravates another condition.

26. Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.
27. Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
28. Any services by a Physician or Provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family Member or relation, even if a Participating Physician or Participating Provider.
29. Services which the Member or Anthem is not legally required to pay.
30. Wigs, except as noted in the Covered Services section.
31. Inpatient services which can be properly rendered as Outpatient services.
32. Disease contracted or injuries resulting from war.
33. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
34. Charges in excess of the Maximum Allowable Amount.
35. Supervisory care by a Physician for a Member who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.
36. Travel, whether or not recommended by a Physician.
37. Certain pulmonary function tests which in the opinion of Anthem do not meet the definition of a covered diagnostic laboratory test.
38. Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.
39. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
40. Radiation therapy as a treatment for acne vulgaris.
41. Acupuncture.
42. Balloon dilation of the prostate.
43. Thermography.
44. Magnetic therapy.
45. Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.
46. The following is a list of procedures which are not covered:
    1. Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient.

       They are not covered *except* in the following cases:

       a. When at least five out of six histocompatibility complex antigens match between the patient and the donor.

       b. The mixed leukocyte culture is non-reactive.

       c. One of the following conditions is being treated:
       - Severe aplastic anemia
       - Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse
       - Myelodysplastic syndrome
       - Secondary acute nonlymphocytic leukemia as initial therapy
       - Acute lymphocytic leukemia in second or subsequent remission
       - Acute lymphocytic leukemia in first remission
       - Chronic myelogenous leukemia in chronic and accelerate phase
       - Non-Hodgkin's lymphoma, high grade, in first or subsequent remission
       - Hodgkin's lymphoma low grade, which has undergone conversion to high grade
       - Neuroblastoma, stage 3 or relapsed stage 4
       - Ewing's sarcoma
       - Severe combined immunodeficiency syndrome
       - Wiskott-Aldrich syndrome
       - Osteopetrosis, infantile malignant
       - Chediak-Higashi syndrome
       - Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and cartilage hair hypoplasia
       - Diamond Blackfan syndrome
       - Thalassemia
       - Sickle cell anemia
       - Primary thrombocytopathy including Glanzmann's syndrome
       - Gaucher disease
       - Mucopolysaccharidoses and lipidoses to include Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome, Morquio's syndrome, Hunter's syndrome, and metachromatic leukodystrophy

All other uses of Allogeneic or Syngeneic Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy or radiation) are not covered.

2. Autologous Bone Marrow Transplantation or other forms of stem cell rescue and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are **not covered *except* for the following:**
   a. Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.
   b. Hodgkin's disease as defined above with an absence of bone marrow involvement.
   c. Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
   d. Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
   e. Retinoblastoma, adjuvant setting after successful induction (consolidation).
   f. Neuroblastoma, adjuvant setting after successful induction (consolidation).

   Autologous Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with high dose chemotherapy and/or radiation), for all other cases are not covered.

Eligibility

To become eligible for membership as a Subscriber under this Benefit Program, the applicant must:

1. Be a resident of the State of Connecticut.
2. Be under age 65.

Renewability of Coverage

We will renew your Policy each time you send us the premium. Payment must be made on or before the due date or during the due month. Your Policy stays in force during this time. We can refuse to renew your Policy only when we refuse to renew all form number N1369 Policies in our state. Nonrenewal will not affect an existing claim.

Premium Rates

The amount, time and manner of payment of Premiums shall be determined by Anthem and shall be subject to the approval of the State of Connecticut Insurance Department.

In the event of any change in Premium, the Subscriber will be given notice at least 30 days prior to such change. Payment of the Premium by the Subscriber of contributions shall serve as notice of the Subscriber's acceptance of the change.